

**ACUPUNCTURISTS**  
**PROFESSIONAL AND GENERAL LIABILITY INSURANCE**  
**(CLAIMS MADE AND REPORTED BASIS)**

Please email this application back to the underwriter with whom you are working.  
For contact information please visit [www.usrisk.com/healthcare.html](http://www.usrisk.com/healthcare.html)

**1. APPLICANT INFORMATION:**

a. Complete name of applicant (if other than parent firm, supply full details of ownership entity) **(use an additional sheet of paper if necessary)**: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ County: \_\_\_\_\_

Contact name: \_\_\_\_\_ Title: \_\_\_\_\_ Email address: \_\_\_\_\_

Phone: \_\_\_\_\_ Web site Address: \_\_\_\_\_ Fax: \_\_\_\_\_

List all other locations **(use an additional sheet of paper if necessary)**: \_\_\_\_\_

b. Professional degree: \_\_\_\_\_

c. Place of Birth: \_\_\_\_\_

d. Applicant is (check all that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> U.S. Citizen (If not, provide status) | <input type="checkbox"/> Self-employed Individual (unincorporated) | <input type="checkbox"/> Self-employed Individual (incorporated) |
| <input type="checkbox"/> Partnership                           | <input type="checkbox"/> Professional Association                  | <input type="checkbox"/> Professional Corporation (for profit)   |
| <input type="checkbox"/> Professional Corporation (non-profit) | <input type="checkbox"/> Employee of _____ (give name of employer) | <input type="checkbox"/> Other (Describe) _____                  |

e. In addition to Acupuncture, do you have other professional specialties? Please describe below:

\_\_\_\_\_

f. Date established: \_\_\_\_ / \_\_\_\_

g. Please state sources and amounts of total gross annual revenue:

Source of revenue	Amount last 12 months	Amount next 12 months
_____	_____	_____
_____	_____	_____

h. If you practice **other than** as an **employee** OR an **unincorporated solo practitioner**, specify:

(i) Formal business, corporate or partnership name: \_\_\_\_\_

(ii) List the names of all partners or members of your professional association/corporation who provide professional services: \_\_\_\_\_

**Attach a copy of your letterhead.**

i. Are you associated with or do you work for a physician or surgeon?  Yes  No

If yes, please give the name and specialty of the physician: \_\_\_\_\_

j. Are you employed by an individual other than that shown in Question 1 above?  Yes  No  
If yes, please attach an explanation, including details of your responsibilities.

k. Are you under contract to any individual or entity other than that shown in Question 1 above?  Yes  No  
If yes, please attach an explanation, including details of your responsibilities. If this contract contains a hold-harmless agreement, please attach a copy of the contract.

l. Are you employed by or under contract to any governmental entity?  Yes  No  
If yes, please attach an explanation, including details of your responsibilities.

m. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?  Yes  No  
If yes, has the applicant implemented procedures to comply with the HIPAA Privacy Rule?  Yes  No  
Provide the name and title of the applicant's Privacy Officer \_\_\_\_\_

n. Provide the following information for all of the states in which you practice:

<u>State</u>	<u>License No.</u>	<u>Effective Date</u>	<u>Expiration Date</u>	<u>Active (Yes/No)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If NONE, please attach an explanation.

o. Are you licensed in accordance with applicable state and federal regulations?  Yes  No  
If no, please attach an explanation.

p. Does your state license or register acupuncturists?  Yes  No  
If yes, advise license number \_\_\_\_\_ Expiration Date: \_\_\_\_\_

q. Are you NCCA certified?  Yes  No  
If yes, please provide date of certification, certificate number, expiration date of certificate:  
Date of Certification: \_\_\_\_\_ Certificate number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

r. Are you currently in active military service?  Yes  No

s. Please describe Professional training including formal classroom education, tutorials, seminars, etc., on attached sheet, or attach a current curriculum vitae (C.V.).

## 2. EDUCATION:

Describe your professional training:

<u>Institution</u> (Name & Address)	<u>Years of Training</u>	<u>Degree or Certification Attained</u>
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____

## 3. EXPERIENCE:

Where have you practiced your profession during the last ten years:

a. Prior Experience - From: \_\_\_\_\_ To: \_\_\_\_\_ Location: \_\_\_\_\_

Practice Activity: \_\_\_\_\_

b. Prior Experience - From: \_\_\_\_\_ To: \_\_\_\_\_ Location: \_\_\_\_\_

Practice Activity: \_\_\_\_\_

c. Prior Experience - From: \_\_\_\_\_ To: \_\_\_\_\_ Location: \_\_\_\_\_

Practice Activity: \_\_\_\_\_

d. Have you ever failed any professional licensing or specialty organization examination?  Yes  No

If yes, please attach a detailed explanation, including dates and location.

**4. YOUR PRACTICE:**

a. Please give the approximate percentages of time spent in the following work locations:

_____% Administrative Office	_____% Other (specify) _____
_____% Classroom	_____% Outpatient Clinic
_____% Nursing Home/Assisted Living	_____% Patient's Home
_____% Professional Office (specify profession) _____	

b. Please indicate the approximate division of your patients or clients among:

Holistic Medicine	_____%	Obstetrical	_____%	Research or Experimental	_____%
Dental	_____%	Disability Evaluation	_____%	(describe)	_____
Drug Addicts	_____%	Pediatric	_____%		
Physician Rehab	_____%	Pain	_____%		
Psychiatric	_____%	Management (describe)	_____		

Must total 100%

c. Do you render professional services directly to patients?  Yes  No  
If yes, please describe these services in detail and indicate whether you are supervised and by whom.

	<b>Percent of time</b>	
Detailed Description of Professional Services	Supervised	Qualifications of Supervisor
_____	_____%	_____
_____	_____%	_____
_____	_____%	_____

d. Do you render professional services that do not involve contact with a patient?  Yes  No  
If yes, please describe these services in detail. \_\_\_\_\_

e. List the number of your employees and volunteers – if none, state none.

Number	Type of employees/volunteers
_____	_____
_____	_____
_____	_____

(i) Are all of the above individuals licensed in accordance with applicable state and federal regulations?  Yes  No

(ii) Do you supervise any individuals other than your own employees?  Yes  No

If yes, give detailed explanation of responsibilities and relationships to the entity which employs these individuals.  
\_\_\_\_\_

Indicate by professions the number of individuals supervised:

Number: _____	Type of profession: _____
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f. Provide number of patient or client encounters:

Type of visit	Number of visits last 12 months	Number of visits next 12 months
Clinic	_____	_____
Office	_____	_____
Other	_____	_____
Total number of visits	_____	_____

g. Do you administer any anesthesia?  Yes  No  
 If yes, please explain and indicate whether you are supervised and by whom. \_\_\_\_\_

h. Do you use the National Council on Certification of Acupuncturists (NCCA) clean needle technique?  Yes  No  
 If No, do you use disposable needles?  Yes  No  
 If No, please attach details. \_\_\_\_\_

(ii) Dispense or prescribe: Drugs?  Yes  No

(iii) Use x-ray or imaging in treatment determination?  Yes  No

(iv) Engage in any procedure, other than acupuncture or the drawing of blood for diagnostic purposes, requiring the penetration of the skin?  Yes  No

(v) Perform investigational or experimental research or therapy on human patients?  Yes  No

i. Do you compound in bulk, manufacture, wholesale oriental/herbal medicine or other nutritional substances or controlled substances?  Yes  No  
 If yes, please provide details \_\_\_\_\_

j. Do you prescribe or dispense any drugs without the countersignature of a physician?  Yes  No  
 If yes, please provide a detailed explanation. \_\_\_\_\_

k. (i) Do you perform or assist in any surgical procedure(s)?  Yes  No  
**If yes, please answer (ii) below.**

(ii) Please list ALL surgical procedures performed (including minor surgery): \_\_\_\_\_

(iii) Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others?  Yes  No  
 If yes, please attach a detailed explanation.

(iv) Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility?  Yes  No  
 If yes, please attach a detailed explanation.

l. (i) Do you perform radiation therapy?  Yes  No

(ii) Psychiatric shock therapy?  Yes  No

**5. APPLICANT HISTORY (ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS)**

Have you:

(i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association?  Yes  No

(ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?  Yes  No

(iii) Ever been treated for alcoholism or drug addiction?  Yes  No

(iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?  Yes  No

(v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?  Yes  No

**6. Do you currently carry the following:**

a. **Professional Liability Insurance?**  Yes  No

List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

Policy Period		Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made or Occurrence?	Premium
From: MM/DD/YY	To: MM/DD/YY					
/ /	/ /					
/ /	/ /					

/ /	/ /					
/ /	/ /					
/ /	/ /					

If claims made, what is the **retroactive date/prior acts date** on your current policy?

**b. Commercial General Liability Insurance?**

Yes  No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made or Occurrence?	Premium

If claims made, what is the **retroactive date/prior acts date** on your current policy?

**7. CLAIMS HISTORY:**

- a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance?  Yes  No

**ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS**

**IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT**

- b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you?  Yes  No

If yes, provide full details. \_\_\_\_\_

- c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?  Yes  No

If yes, fully describe the circumstances and follow up action taken: \_\_\_\_\_

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

\*Notice applicable in most states:

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date